

April 17, 2008

CalPERS Health & Disease Management Initiative

Future Directions Report to Staff

MERCER

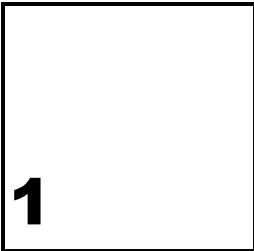


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Consulting. Outsourcing. Investments.

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Executive Summary

Background

California Public Employees Retirement System (CalPERS), in its commitment to deliver a best in class health and disease management (HM&DM) program, engaged Mercer Health and Benefits (Mercer) to assist in determining the best approach to delivering this program to its population. Objectives in offering this program are to:

- Improve population health
- Reduce avoidable health care utilization
- Increase member satisfaction
- Optimize program use

To determine the best approach for delivering this program, Mercer conducted the following activities:

- Surveyed and conducted site visits with current health plans (Blue Cross of California, Blue Shield of California and Kaiser) to assess current capabilities compared to best practices. Key program components assessed and addressed in this report include:
 - Health Risk Assessment (HRA)
 - Lifestyle Management (LM)
 - Disease Management (DM)
- Reviewed CalPERS Staff resources and infrastructure to support a best in class HM&DM program
- Analyzed whether leveraging programs with the existing health plans or carving out HM&DM program components to specialty vendors would achieve a best in class program.

The following summarizes our key findings and recommendations for CalPERS to move forward with its commitment.

Key Findings

- **Programs delivered through the health plans lack needed integration:**
 - Each health plan offers HM&DM programs and services across the health continuum. How they are delivered and the level of integration among components varies:
 - HRA, LM and DM programs operate and are delivered in silos with minimal connections.
 - Programs and services are not CalPERS-specific and health plans generally lack the flexibility required to tailor programs and communications for CalPERS' diverse populations.
 - Health plans do not emphasize the value of the HRA, missing the opportunity to educate participants and link them to LM and DM programs and services.
 - Systems that support specific program components are unique, in most cases, and are not interconnected to facilitate referrals, follow-up, tracking and reporting.
- **Participation rates in the health and disease management programs are poor:**
 - Health plans have provided very limited data on how many, and to what degree, CalPERS members are engaging in HM&DM programs and services.
 - Based on the limited data Mercer has received:
 - Between 1% and 7% of CalPERS' members (varying by health plan) have completed a HRA. Best in class programs, using incentives and strategic communications, achieve greater than 50% participation annually and a minimum of 70% over a three year period.
 - Available statistics about CalPERS' members engaged in LM programs (e.g. quit smoking, increased physical activity) indicate minimal engagement. Best in class programs engage a minimum of 40% of the HRA participant group in LM interventions.
 - Active participation rates for all of CalPERS' DM programs are unknown. For best in class DM programs that target similar conditions to CalPERS' current programs, Mercer would expect that 10% of the population would be eligible for a program. Of those, we would expect that 35% of the eligible population to be actively engaged in the program. Reports Mercer received did not distinguish active participation (telephonic assessment and support from a disease manager).
- **Current health plan reporting is inconsistent and limited in scope:**
 - Currently, the health plans are reporting limited performance metrics to assess the programs' performance. For the key disease states where programs are available, 143 operational and clinical metrics are commonly offered by best in class providers. Only 26 can be consistently reported by all health plans.

CalPERS: Future Directions

- Data definitions, measurement methodologies and reporting practices vary among the plans. Generally plans are not providing all of the minimum data elements to CalPERS to support data analytic efforts and validate reporting.
- **CalPERS' Staff resources are not appropriately deployed to support a best in class program:**
 - Staff has multiple responsibilities, preventing the focus and efficiencies necessary to strategically develop, implement, manage and improve HM&DM programs and services.
 - Although current Staff in the data and clinical areas of CalPERS has expertise in their respective areas, additional resources are needed with the necessary skill sets to support and manage a robust HM&DM program, in addition to their clinical oversight responsibilities. Functions that are most resource-constrained include:
 - HM&DM program strategy
 - HM&DM program operations
 - Data analytics
- **Awareness of available programs is limited:**
 - Communications to members about HM&DM programs and services are limited.
 - Methods to deliver communication materials are limited to member-wide or targeted populations through mailings to the home, or online communications. Few members are aware of the value of the breadth of programs offered; consequently most of CalPERS' population has not accessed online services provided through the health plans.

Recommendations

Mercer recommends the following to support CalPERS' vision to offer a best in class HM&DM program.

- **Implement a comprehensive performance monitoring approach beginning in 2008**
 - By requiring consistent reporting on common metrics that address programs and services across the health continuum, CalPERS can more efficiently manage program performance.
 - Requiring minimum data to be submitted to CalPERS will enable efforts such as continuous improvement in program processes.
 - Data provided to CalPERS will begin to allow it to develop tailored interventions and improve engagement in the HM&DM programs.
- **Develop an action plan to expand program offerings to ensure consistency across health plan programs in 2009**
 - In the short term, ensure each health plan offers consistent programs at no additional cost.

CalPERS: Future Directions

- Hold health plans accountable for achieving improved participation and engagement rates in these programs through performance guarantees and contract language that leverages new integration capabilities.
- Ensure that HRA participation becomes a priority for the plans through the use of CalPERS-branded communications.
- **Carve out HRA and LM programs from all plans effective 2010¹**
 - Specialized vendors have targeted campaigns which result in improved engagement and participation. Consequently, by carving out these programs, we expect that participation and engagement rates will improve to best in class levels.
 - Specialized vendors understand behavior change and are able to tailor messages and programs to fit diverse populations, such as CalPERS, while understanding their risks and change in behaviors over time.
 - Carving out will also enable CalPERS to quickly adopt a best in class model across the entire membership, allowing for standardization of delivery approaches, engagement strategies (i.e., communications and incentives), and performance guarantees and reporting.
 - Best in class HRA and LM vendors use sophisticated technologies to support advanced integration of programs, resulting in an improved member experience.
 - Consolidation of HRA and LM programs will allow CalPERS' Staff to be more efficient in monitoring program/vendor performance.
- **Carve out DM programs from the Blue Cross and Blue Shield Plans effective 2011**
 - DM active participation and engagement are expected to increase if CalPERS pursues carving out DM programs to a specialty vendor that delivers best in class programs.
 - Mercer does not recommend carving out DM from Kaiser at this time because their physician-centric Staff model appears to be effective in managing the chronically ill; however, program components and reporting should be aligned with CalPERS' business requirements to adequately evaluate, report and integrate the Kaiser program data with the carve-out vendor data.
 - Program integration will improve. Currently, two health plans use a subcontractor(s) for DM programs that are not providing seamless coaching for individuals with multiple risks.
 - DM programs will have best in class system support, allowing integration to be more technologically advanced with other program components.
 - Staff's level of effort to support DM program monitoring will be much more streamlined, allowing for more focus on program and process improvements.
 - CalPERS will have more control to ensure that the vendors will provide:

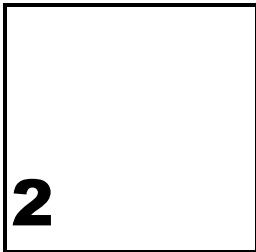
¹ Carve out of Kaiser HRA and LM programs will depend on 2008 year end review of performance improvements in the areas of operational and clinical outcomes.

CalPERS: Future Directions

- CalPERS-specific tailored engagement strategies (e.g. communications and incentives)
- Patient empowerment through education, skill building and behavior change
- Engagement of the patients' physicians in the delivery of DM programs and services, and
- Performance guarantees and reporting
- **Reorganize/develop a dedicated HM&DM program management team**
 - Appoint the following key positions:
 - Strategic Program Leader to assume responsibility for development and execution of a multi-year, strategic plan and integration with other CalPERS initiatives (e.g., pharmacy integration with the DM program).
 - Program Operations Leader to assume day-to-day responsibility for operationalizing the strategic plan and working to oversee internal and external partners and integration of program components across the health continuum.
 - Program Data Analytics Leader to monitor program performance across all program components, bringing together multiple sources of data consistently, encouraging proactive management and process improvement.
 - Assess the need for additional Staff resources to identify candidates to support the dedicated HM&DM team.
- **Separate the activities associated with implementing a single administrator from those of the HM&DM program**
 - Not all single administrators have best in class HM&DM capabilities.
 - Implementation processes are unique for both initiatives.
 - Establishing unique contracts for a single administrator and for the carve-out HM&DM vendor(s) will allow CalPERS to have more control over renewal processes and future vendor changes.

The following report includes: a review of key findings observed throughout the project; rationale and support for each of the recommendations outlined; and, an action plan for CalPERS' consideration. Report sections include:

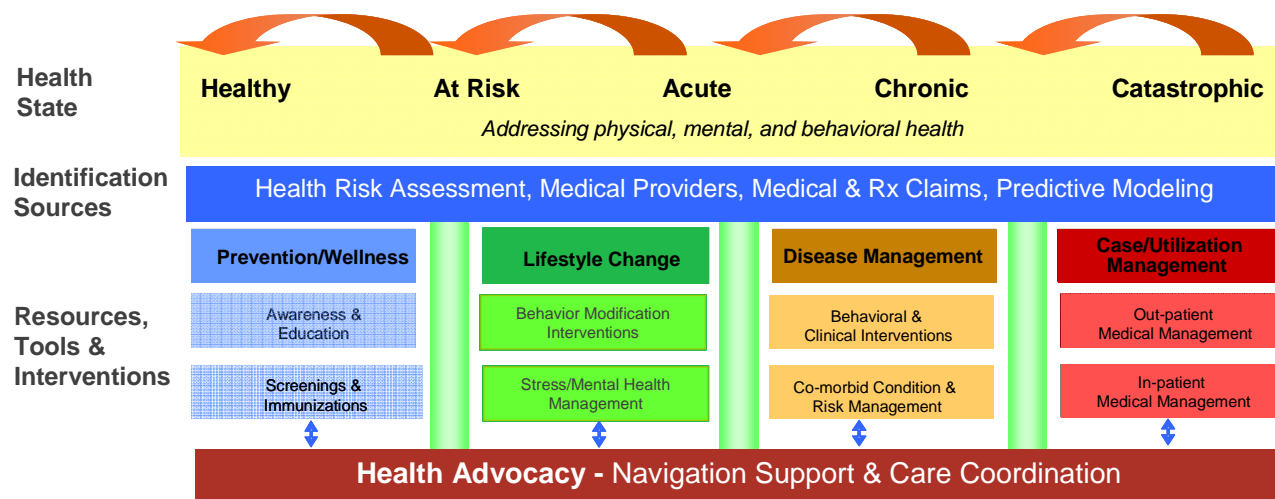
- Critical Elements for Success
- Current State: Program and Key Performance Gaps, and Performance Monitoring
- CalPERS "Best in Class" HM&DM Opportunities and Recommendations
- Three-year Proposed Action Plan
- Single Administrator Implications



Best in Class Health & Disease Management

Population Health: Critical Elements for Success

A best in class strategy (illustrated below) addresses the health of the entire population and integrates programs and services from a person-centric perspective. Programs and services on the left hand of the continuum are generally referred to as Health Management (HM) programs and include the use of a Health Risk Assessment (HRA) and Lifestyle Modification (LM) programs in addition to services to support prevention and early detection. Programs and services on the right hand side are generally referred to as Disease Management (DM) programs and services. Supporting the entire population are program components such as Nurse Lines (NL), Web Portals and Health Advocacy (HA). This report primarily focuses on HRA, LM and DM services, making references periodically on key findings and opportunities for the future in the areas of NL, Web-portals and HA services.



Integration: An Element for Success

To successfully design a best in class HM&DM program, integration among all HM&DM program components is required. The HM&DM vendors are in various stages of integrating capabilities.

In our experience, significant time and resources are required to develop the systems to fully integrate programs and services. This will be challenging for the health plans, who in several instances, subcontract for specific program components. Alternatives to current health plans for CalPERS' consideration include:

1. **Specialized and niche vendors:** Offer specific programs or services such as HRA, LM, DM, Web-Portals, Health Advocate Services
2. **End-to-end vendors/integrators:** Offer either internal or subcontracted programs and services that span the entire health continuum, including HM, DM, Case and Utilization Management, Health Advocacy and Decision Support. Integrator services include such things as data management, analytics and reporting.
3. **Entrants from related industries:** Typically in a related health industry (e.g. general insurance, pharmacy benefit management) these players are entering this industry to provide more end-to-end solutions for members beyond their core businesses.

Today's providers of HM&DM programs and services are in various stages of integration, as illustrated on the following page. Few offer complete integration (as defined as Comprehensive Integration as noted below in the table), but most are moving in that direction. The more integrated programs are, the better the experience for the member and CalPERS will be able to focus Staff resources on process improvement and other strategic activities.



Program Elements	Basic	Cooperative	Coordinated	Comprehensive Integration
Programs & Services	<ul style="list-style-type: none"> ▪ Siloed program and service management and delivery 	<ul style="list-style-type: none"> ▪ Individual meetings with program component owners/ vendors ▪ Random integration, manual referrals, follow-up and tracking ▪ Some program integration (e.g., medical and DM) 	<ul style="list-style-type: none"> ▪ Annual program and service component owner/vendor meeting ▪ Random, system-supported integration, manual referrals, follow-up and tracking ▪ Medical and some HM&DM integration 	<ul style="list-style-type: none"> ▪ Total Program Management approach; ongoing strategic planning, process improvement ▪ System-supported integration, automating referrals, follow-up and tracking ▪ Full partnership/integration between programs and services; seamless experience for member
Communications	<ul style="list-style-type: none"> ▪ Unique to each program or services 	<ul style="list-style-type: none"> ▪ Some communication linkage between programs 	<ul style="list-style-type: none"> ▪ Some client-specific communications between programs 	<ul style="list-style-type: none"> ▪ Fully integrated and client-specific ▪ Consistent messaging
Identification for HM&DM Programs	<ul style="list-style-type: none"> ▪ No linkage 	<ul style="list-style-type: none"> ▪ HRA data used for LM identification 	<ul style="list-style-type: none"> ▪ HRA, medical, pharmacy data used for LM or DM identification 	<ul style="list-style-type: none"> ▪ HRA, medical, pharmacy, lab data used for all HM&DM program identification
Measurement & Evaluation	<ul style="list-style-type: none"> ▪ Focus on expense control 	<ul style="list-style-type: none"> ▪ Simple analysis of medical data 	<ul style="list-style-type: none"> ▪ Evaluation of process, impact and outcomes 	<ul style="list-style-type: none"> ▪ Total cost and health outcomes (across care continuum)

CalPERS: Future Directions

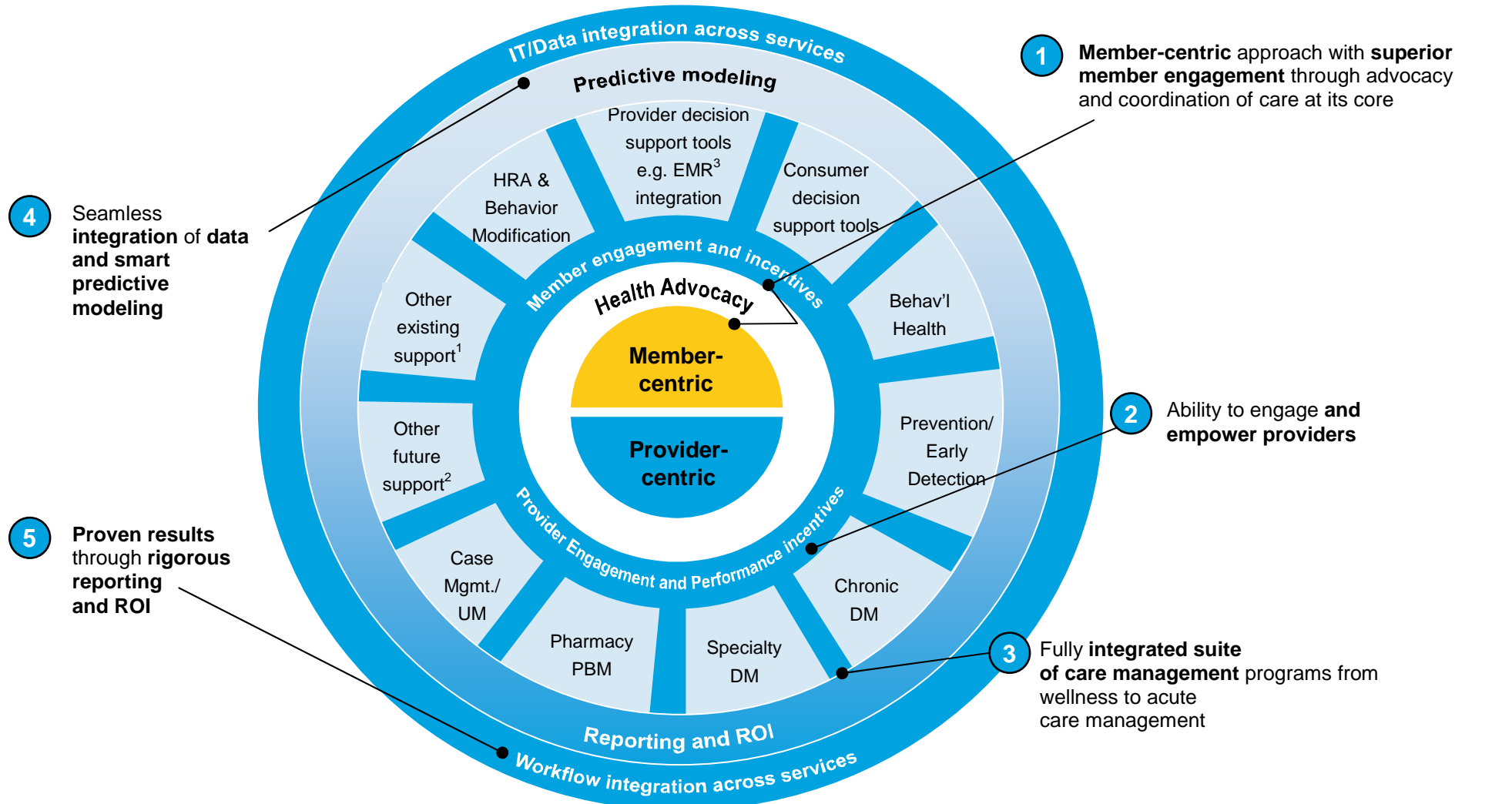
Note: Health plans and specialty vendors that offer “end-to-end solutions” may not be more integrated than specialty or niche vendors that have long-standing strategic alliances. The vendor landscape is evolving rapidly and vendors require continuous evaluation to determine level of integration.

For purposes of this initiative, Mercer has evaluated CalPERS’ key HM&DM programs (e.g., HRA, LM and DM) to determine the current level of integration occurring with its plans. After review, Mercer has determined that CalPERS’ health plan-based HM&DM program and services are generally in the early stages of integration, ranging from basic to coordinated integration levels as defined in the table above. Here are a few examples:

- Many programs and services are being delivered using early stages of integration that are not sophisticated and do not help to engage participants (e.g. health coach provides referrals between program components with little to no follow-up and provides information verbally, instead of providing direct transfers). Specifically:
 - Communications offered are population-based and not CalPERS-specific.
 - Identification criteria for HM&DM candidates varies among health plans.
- Health plans stated that they are striving to improve integration in the future (e.g. consistent, system-supported integration with automated referrals, follow-up, tracking and reporting).

Mercer has extensive experience working on behalf of our clients to design, develop and implement successful HM&DM programs that are fully integrated. The illustration on the following page presents Mercer’s view of a best in class, population health model that is fully integrated.

Mercer Model for Best-in-Class Integration



1. "Other existing support" includes: Medical management services such as pre-certification; nurse-line support; Rx detailing / monitoring; end-of-life services, employee-assistance programs
2. "Other future support" could include: enhanced care models that support both the patient and the physician.
3. Electronic Medical Record (EMR).

Other Critical Elements for Success

Contracting for best in class HM&DM programs and achieving full integration is not all that is necessary to achieve successful health improvement and positive clinical and financial outcomes. Mercer has over 10 years experience designing and implementing programs on behalf of plan-sponsors. As an industry leader, we have identified common characteristics, or core elements, that are required to launch and sustain a best in class program. This approach has yielded significant financial results to several of the clients who have implemented it. As an example, one client, Pepsi Bottling Group (PBG), has been nationally recognized by receiving the C. Everett Koop National Health Award for its program and results. Key highlights include:

- 68 to 72% of the eligible employee and spouse population completed an HRA over each of the last three years of the program
- 35% of identified individuals with high/moderate risk participated in at least one LM program
- 32% of employees who completed LM programs reduced their risk level in the targeted behavior/risk area; significant risk reduction occurred from baseline to one-year follow-up in all six areas targeted by interventions
- Three year medical cost trend averages of 5.6% each year have outperformed national averages
- HM&DM programs demonstrated estimated savings of \$118.55 per participant per month in healthcare costs
- Over 96% of participants were satisfied with the programs
- In 2007, PBG received the Best Employer - Healthy Lifestyle Gold Award from the National Business Group on Health.

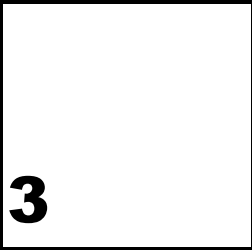
The core elements and recommendations for CalPERS' consideration are outlined in the following table:

Core Elements	Recommendations ¹
Solid infrastructure and strategic management of HM&DM program	<ul style="list-style-type: none"> ▪ Establish a dedicated HM&DM team, with Strategic and Operational Leaders; assess Staff resources to determine additional needs to support process improvements and strategic activities ▪ Develop and execute a three-year action plan for the CalPERS HM&DM program, implementing process improvements on a proactive basis ▪ Continue efforts to standardize, manage and hold health plans accountable within established or new contracts to support HM&DM programs by: <ul style="list-style-type: none"> - Adding CalPERS-specific language for improved HM&DM integration - Expanding performance guarantees to include process improvement guarantees (e.g., DM program completion) - Define consistent performance monitoring criteria, minimum data requirements and metrics ▪ Establish an annual calendar of meetings with health plans that focuses on improvement strategies and evaluation of program performance measurements: <ul style="list-style-type: none"> - Monthly and quarterly meetings: identify and develop process improvement strategies - Quarterly and annual meetings: evaluate and assess impact and outcomes from a process, clinical and financial measurement perspective
Data-driven, evidence-based programs and services	<ul style="list-style-type: none"> ▪ Work strategically with health plans to consistently monitor, manage, and measure programs and services utilizing CalPERS-specific HRA, LM & DM participation, process and clinical data elements ▪ Implement early identification and management of health risks to minimize the costs associated with health risks and disease conditions (e.g., use HRA to identify candidates for LM or DM) ▪ Vendors should provide all minimum HRA, LM and DM data requirements to CalPERS ▪ Increase and apply operational and clinical experts to verify all non-data driven performance measures reported by health plans/potential carve-out vendor(s) (e.g. smoking status, referrals to behavioral health, lab results)

¹ These recommendations should apply to any possible carve-out vendor(s) that are added in the future.

CalPERS: Future Directions

Core Elements	Recommendations ¹
Stakeholder engagement for optimal HM&DM programs	<ul style="list-style-type: none"> ▪ Work with constituent groups/public agencies to promote HRA participation ▪ Engage constituent groups/public agencies to support CalPERS' HM&DM programs so they become involved with the promotion of CalPERS' programs to increase awareness, participation and reinforce value across the membership
Incentive strategy & design to encourage participation and healthy behaviors	<ul style="list-style-type: none"> ▪ Work with constituent groups/public agencies to solicit input and gain support for a multi-year incentive strategy
Comprehensive communication strategy to increase member awareness and value	<ul style="list-style-type: none"> ▪ Establish CalPERS-specific branded communications for HM&DM programs to differentiate CalPERS' provided services versus services provided by medical groups and/or constituent groups/public agencies ▪ Work with health plans to consistently utilize the CalPERS-specific brand for all communications received by members who are identified or engaged for HM&DM programs ▪ Consider establishing a single web-portal, supported by single sign-on, for members to access all HM&DM programs and services
Measurement & evaluation strategy	<ul style="list-style-type: none"> ▪ Continue to identify HRA, LM and DM minimum data metrics and program methodologies; require current health plans and future vendor-partners to provide these metrics and methodologies ▪ Expand HM&DM program offerings and performance monitoring to include health risks and other conditions based on results from the chronic conditions cost analysis (e.g. stress, depression and musculoskeletal program)



Current State: Programs and Key Performance Gaps

Health Plan Situation Overview

Mercer evaluated each health plan's HM&DM program, comparing capabilities and results to vendors who are achieving best in class results in terms of participation rates, behavior change, health risk reduction, clinical compliance and reduced utilization. Highlights of our findings on programs and key performance gaps include:

- Each health plan offers the core components of HM&DM, including:
 - Health Risk Assessment (HRA)
 - Web Portals with health information/education
 - Lifestyle Modification (LM) programs (*CalPERS does not contract for this service with Blue Shield*)
 - Nurse Line (NL) services
 - Disease Management (DM) programs
- Each health plan has a unique philosophy and approach for how they manage population health, deliver their respective programs and services, and report how the program is working. The impact is that:
 - There is disparity in populations being managed, as well as how, when and where interventions are delivered
 - Three distinct programs multiply the effort required by CalPERS' Staff to effectively and efficiently monitor performance, facilitate process improvements and strategically manage the program
- Many programs are delivered in silos, using sub-contracted vendor services that rely on unique IT system platforms to support their interventions. The lack of integration between programs can create a confusing experience for the member and limit CalPERS' ability to understand the programs' impact.

CalPERS: Future Directions

The table below presents our key findings.

Current Situation	Implications
Health Risk Assessment	
<ul style="list-style-type: none">▪ Participation rates for all health plans are not reported on a CalPERS-specific basis; however, data available indicates less than 1% of CalPERS members have completed the HRA. Factors include:<ul style="list-style-type: none">– The HRA is only offered online¹– Health plan communications are limited in scope and to date have yielded poor results– There are minimal or no incentives available²▪ HRA results are not being leveraged effectively to identify candidates for LM and/or DM▪ HRA results are not included as part of electronic medical records	<ul style="list-style-type: none">▪ CalPERS is missing an opportunity to understand population health risks to support data-driven decisions on future program investments▪ Industry best practice programs achieve 70% HRA participation over a three year period of time▪ HRA results assist members in understanding their health risks and identifying opportunities to participate in LM and DM programs
Lifestyle Modification	
<ul style="list-style-type: none">▪ CalPERS has not purchased LM programs from one of the health plans▪ Not all plans track and/or report participation rates or risk reduction statistics on a CalPERS-specific basis▪ The two plans that offer LM programs do not effectively use HRA data to identify and engage individuals in LM interventions▪ Where data is available, Mercer identified less than 1% of the entire CalPERS population participating in a LM program during 2004-2007	<ul style="list-style-type: none">▪ Without LM program participation opportunities are missed to reduce risk, change behaviors, and avoid early onset of chronic conditions▪ Best in class programs engage a minimum of 40% of the HRA participant group in LM interventions

¹ CalPERS does not contract for a paper-based HRA delivery option.

² One health plan offers an incentive for HRA completion; however, this reward is new and has not been extensively communicated.

Current Situation	Implications
Disease Management	
<ul style="list-style-type: none"> ▪ All plans offer Asthma, Coronary Artery Disease, Congestive Heart Failure and Diabetes DM programs. Two plans offer a COPD DM program to all eligible members and the third has a pilot program in progress and plans to implement it for all members in 2008 ▪ Philosophies and approaches for managing member health vary among plans in the following main areas: <ul style="list-style-type: none"> – Role of the physician in delivering or supporting DM programs – Approach and timing for identifying, stratifying and engaging members – “Touch” rates in terms of frequency of calls, emails and mailings – Processes, tools and resources to facilitate coordination of care/integration between programs and services – Electronic capabilities to monitor, track and report on program performance ▪ Data to identify eligible participants varies from plan to plan. Medical and pharmacy claims are the only common data source used by all plans. Plans do not effectively leverage HRA data to identify members with chronic conditions ▪ Active participation rates for all of CalPERS’ DM programs are unknown. Reports Mercer received did not distinguish active participation (telephonic assessment and support from a disease manager). Active participation requires completion of an initial assessment and periodic telephonic or in-person coaching by their PCP or disease manager. ▪ It is difficult to understand how well each DM program is performing due to differences in measurement and reporting approaches (e.g. definition of participation, methodologies to establish baselines and calculate improvements) 	<ul style="list-style-type: none"> ▪ It is very complicated for CalPERS to effectively and efficiently manage three distinct DM programs and monitor in a consistent fashion the performance of each health plan ▪ For best in class DM programs that target similar conditions to CalPERS’ current programs, Mercer would expect that 10% of the population would be eligible for a program. Of those, we would expect 35% of the eligible population to be actively engaged in the program.

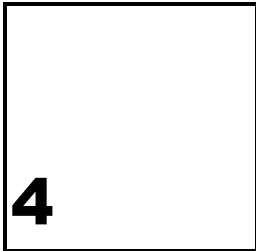
Performance Monitoring

The result of this assessment of health plan capabilities to meet best in class reporting includes the following findings:

- Staff and Mercer identified 143 operational (process and impact) and clinical measures to support the monitoring of five core disease states
- Twenty-six (26) of the 143 performance monitoring measures can be consistently reported across all health plans
- Measures are reported at different frequencies by the health plans
- There are disparities among the health plans in terms of consistent definitions and methodologies for measurement across disease states (e.g., for asthma all health plans can report on “enrolled”, but not all can report on “identified”)
- Two of three plans offer a COPD DM program to all eligible members. Common metrics for all three health plans can be determined later in 2008 after the implementation of the COPD program at the third health plan

The number of common metrics that all health plans can support by disease-state category are:

	All 3 Health Plans Report	2 Health Plans Report	1 Health Plan Reports	No Health Plans Report
Asthma	4	11	6	1
CAD	6	15	5	5
COPD	0	15	9	0
Diabetes	10	13	4	7
Heart Failure	6	12	8	6
Total	26	66	32	19



CalPERS “Best in Class” HM&DM Options

CalPERS has two options to develop a best in class HM and DM program. Options include:

- Continue with current health plans, requiring process improvements and enhancements to HM&DM programs
- Carve out specific components to best in class vendors with strong integration capabilities

Continue with Current Health Plan HM&DM Program(s)

This option will require the most effort by CalPERS’ Staff to achieve standardization and achieve best in class results. CalPERS’ health plans have indicated willingness to work with CalPERS to improve processes and achieve improved results.

Recommendations	Benefits to CalPERS
<p>Address Needs Across Health Continuum – Working With Each Plan to:</p> <ul style="list-style-type: none">▪ Offer HM&DM programs to address member needs across health continuum<ul style="list-style-type: none">– Add LM and COPD DM programs (at no additional cost) to fill the current gap in programs and monitor data to identify additional health risks and conditions to manage▪ Develop process improvement strategies to integrate programs▪ Agree upon performance guarantees for achieving process improvement milestones▪ Develop strategies that support patient empowerment and enhance the patient/physician relationship	<ul style="list-style-type: none">▪ Best in class programs that manage population health offer short- and long-term strategies to control health care costs through:<ul style="list-style-type: none">– Prevention– Early detection– Risk reduction– Avoidance of complications– Improved health status

CalPERS: Future Directions

Recommendations	Benefits to CalPERS
<p>Standardize HM&DM Program Delivery Approaches</p> <ul style="list-style-type: none"> Address gaps in HM&DM delivery modes <ul style="list-style-type: none"> Offer mail-based HRAs, telephonic and mail-based LM and DM programs across all plans at no additional cost Develop business requirements (e.g. how care is coordinated when an individual is engaged in LM and DM at the same time) to support program integration, working with plans to develop common process flows Explore options to reduce variations in program delivery approaches (e.g. standardize eligibility criteria, participation definitions, and identification and stratification methods) Work with health plans to utilize additional data (i.e. HRA, lab data) and use predictive modeling to identify eligible participants for LM and DM programs 	<ul style="list-style-type: none"> CalPERS' members have diverse needs and learning styles, requiring program and delivery options to appeal to a broader population and increase participation rates Integrated programs improve the member experience and overall satisfaction as care is coordinated and resources are easier to navigate Standardization will improve CalPERS' ability to monitor programs
<p>Increase Engagement</p> <ul style="list-style-type: none"> Develop a CalPERS-specific program brand, working with plans to incorporate in promoting and communicating CalPERS HM&DM programs Develop a multi-year communication strategy, using HM&DM data to determine population-level and targeted messages Explore use of incentives, including non-financial incentives, to promote participation in programs 	<ul style="list-style-type: none"> Using a specific CalPERS brand will increase awareness and recognition of all HM&DM benefits offered by CalPERS Increased awareness and promotion of programs will have an incremental impact on participation rates over time. Coupled with incentives, CalPERS can achieve best in class participation rates
<p>Enhance Performance Monitoring Approach</p> <ul style="list-style-type: none"> Expand metrics to include all program components (e.g. HRA, LM) Standardize metric definitions (e.g. participation) and method for measurement Require participation tracking where it is not currently being reported Add process metrics to monitor identification, stratification and ongoing engagement patterns Require health plans to support minimum reporting requirements Expand performance guarantees to include process improvement objectives (e.g., tracking and reporting HRA participation rates, incorporating HRA data into Personal Health Records and Electronic Medical Records) Hold plans responsible for submitting performance data to CalPERS as outlined on the following page 	<ul style="list-style-type: none"> Expanding metrics provides CalPERS information for ongoing strategy development and process improvement across all programs Standardizing metric definitions and methods across all plans allows CalPERS to compare program outcomes across all health plans Requiring participation tracking across all programs and plans, and separating participation by groups (e.g. employee versus spouse, divisions) allows CalPERS to understand how programs are utilized and how to address ongoing communication strategies

Recommended Additional Data Elements for Comprehensive Program Evaluation

Mercer recommends the following data elements be provided to CalPERS as programs and services evolve. Best in class providers of HM&DM programs routinely include these data elements in their standard reporting. Each file should be provided on a person-centric basis (each data element tied to a unique, personal identifier).

HRA

- Complete response set (e.g., every answer to every question)
- Biometric values (as available; including both self-reported and from screening)
- Derived risks (e.g., risk level for each modifiable lifestyle risk such as inactivity, tobacco use)
- Chronic conditions (e.g., self-reported such as asthma, low back pain, diabetes, etc.)

LM

- Derived risks (e.g., risk level for each modifiable lifestyle risk such as inactivity, tobacco. May be on HRA file if same vendor)
- LM Enrollment Status/Level of Engagement (e.g., Enrolled Telephonic Coaching, Enrollment Online/Mail, Unable to Contact/Pending, Opt Out)
- LM Program Enrolled (e.g., Smoking Cessation, Weight Management)
- LM Enrollment Date
- Program Modality (Phone, Mail, Online)
- # LM Coaching Calls (Cumulative number of completed calls with a Health Coach)
- LM Participation Status (e.g., Remaining Active, Graduated, Dropped Out)
- LM Program Graduation Date

DM¹

- Identified primary conditions (e.g., asthma, CAD, COPD, Diabetes, HF)
- Identified co-morbid conditions (e.g. depression, obesity)
- Overall Acuity (e.g., Level 1-4 or L, M, H; Note: point-in-time snapshot)
- DM Enrollment Status/Level of Engagement (Enrolled Telephonic, No Support/No Opportunity, Unable to Contact, Opt Out, False Positive)
- DM Condition Enrolled
- DM Enrollment and Disenrollment Dates
- DM Calls Completed (Cumulative number of completed calls with an RN, excluding initial intake assessment)
- DM Participation Status (e.g., Remaining Active, Graduated, Dropped Out)

¹ Plan-specific DM performance monitoring details are provided in the technical appendices. Not all health plans can report on these measures currently.

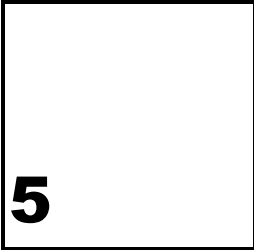
Carving Out HM&DM Programs from Current Health Plan(s)

Although we recommend a three-year, phased in approach to carving out HRA/LM and DM programs and services, the following reviews all carve-out options.

HRA Carve-Out	Recommendations	Benefits
Identify and partner with one HRA specialty vendor; leaving LM and DM with health plans	<ul style="list-style-type: none"> Not recommended The HRA should be fully integrated with an intervention capability, most commonly LM 	<ul style="list-style-type: none"> None
HRA & LM Carve-Out	Recommendations	Benefits
Identify and partner with one HRA & LM specialty vendor; leaving DM with health plans. Vendor must have experience and proven ability to deliver or partner with other specialty vendors to deliver best in class, integrated programs that address the entire health continuum	<ul style="list-style-type: none"> Recommended; effective 2010 Two of three health plans indicated willingness to support other HRA and LM options Staff will assess Kaiser HRA and LM operational and impact measures at the end of 2008 to determine if HRA and LM programs should be carved out or remain with Kaiser Additional effort required with carving out LM and not DM to create program process flows that support care coordination 	<ul style="list-style-type: none"> HRA and LM specialty vendors use methods to effectively increase participation rates. Participation is expected to increase to best in class levels Specialized vendors have targeted campaigns, allowing them to better engage the population and increase participation rates Specialized vendors understand behavior change and tailor messages and programs to fit diverse populations, such as CalPERS Will enable CalPERS to quickly adopt a best in class model across the entire membership, allowing for standardization of delivery approaches, engagement strategies (i.e., communications and incentives), and performance guarantees and reporting Best in class HRA and LM vendors use sophisticated technologies to support advanced integration resulting in an improved member experience Consolidation of HRA and LM programs will enable CalPERS' Staff to focus its efforts on program management

CalPERS: Future Directions

DM Carve-Out	Recommendations	Benefits
<p>Identify and partner with one DM specialty vendor that has experience and proven ability to partner with other specialty vendors to deliver best in class, integrated programs that address the entire health continuum</p>	<ul style="list-style-type: none"> ▪ Carve out DM programs from the Blue Cross and Blue Shield Plans effective 2011 ▪ Retain Kaiser's DM program ▪ Considerations in implementing this approach are: <ul style="list-style-type: none"> – High initial transition costs – More internal resources needed – Long implementation timeline 	<ul style="list-style-type: none"> ▪ DM specialty vendors use effective methods to increase active participation in DM programs. Active participation and engagement are expected to increase ▪ DM programs and reporting will be better integrated. Currently, plans with multiple vendors for DM programs are not providing seamless coaching for individuals with multiple risks ▪ DM programs will have best in class system support, allowing integration to be more technologically advanced with other HM&DM programs ▪ The level of effort to support DM program monitoring will be much more streamlined and enable Staff to focus on process improvements ▪ CalPERS can direct the selected carve-out vendor to provide: <ul style="list-style-type: none"> – CalPERS-specific tailored engagement strategies (e.g. communications and incentives) – Patient empowerment through education, skill building and behavior change – Physician involvement in the delivery of DM programs and service to participants – Improved performance guarantees and reporting



Three-year Proposed Action Plan

In this section, Mercer presents a three-year action plan, incorporating the recommendations outlined in the previous sections. The recommendations are aggressive, adopting all of the critical elements required to achieve a best in class program. The action plan does not include any specific recommendations for the investigation or implementation of any single administrator initiative.

The action plan includes the following key categories:

- Infrastructure to strategically manage a sustainable program
- Data-driven, evidence-based programs and services
- Stakeholder engagement activities to optimize program participation
- Incentive strategy & design to encourage participation and healthy behaviors
- Comprehensive communication strategy to increase member awareness and value
- Measurement and evaluation strategy

CalPERS: Future Directions

Core Elements	2009	2010	2011 & Beyond
Infrastructure to strategically manage a sustainable program	<ul style="list-style-type: none"> ▪ Develop strategically focused, dedicated HM&DM team; appointing a team lead with responsibility for all HM&DM programs ▪ Assign dedicated HM&DM team members, defining roles, responsibilities and training needs ▪ Expand clinical staff resources in managing HM&DM programs to ensure sufficient focus and availability to monitor program performance ▪ Implement annual calendar of management meetings with health plans exclusively focused on assessing HM&DM performance, and process improvement plans ▪ Add staff for the following key positions: Strategic Plan Leader, Program Operations Leader and Data Analytics Leader 	<ul style="list-style-type: none"> ▪ Add additional staff to secure expertise required to support successful HM&DM program ▪ Assign HM&DM team members the responsibility to collaborate with health plans and provider groups to: <ul style="list-style-type: none"> – Identify opportunities to increase awareness and promote referrals into CalPERS' HM&DM programs – Create approaches to improve the provider-patient relationship as an integral component of the HM&DM program – Encourage plans to design HM&DM programs to be physician-centric AND patient-centric ▪ Engage the largest/key constituent groups/state agencies in the promotion of HRAs and CalPERS' programs 	<ul style="list-style-type: none"> ▪ Refine/enhance dedicated HM&DM team staffing model ▪ Continue to work with the constituent groups/state agencies to promote HRA participation, and become involved in the promotion of CalPERS' programs ▪ Assess and revise HM&DM strategic plan as needed for the future

CalPERS: Future Directions

Core Elements	2009	2010	2011 & Beyond
<p>Data-driven, evidence-based programs and services</p>	<ul style="list-style-type: none"> ▪ Initiate procurement process to carve out HRA/LM for 2010 plan year for two of the three health plans: <ul style="list-style-type: none"> – Vendors should be assessed for ability to support DM and integrated HM&DM programs – Kaiser may or may not be carved out for HRA/LM depending on 2008 year end review of HRA and LM operational and clinical outcomes ▪ Establish carve-out HRA/LM contract that supports the strategic plan and includes: minimum business requirements, minimum HRA/LM data requirements, physician-centric model and patient-centric model, competitive pricing, communication guidelines, best in class performance guarantees ▪ During Q3/Q4 2009, coordinate with health plans to ensure implementation activities are effectively integrating program with other health plan programs 	<ul style="list-style-type: none"> ▪ Launch carve-out of HRA/LM programs <ul style="list-style-type: none"> – Facilitate procurement process to carve out DM for 2011 plan year for Blue Cross and Blue Shield ▪ Establish carve-out DM contract that supports strategic plan and includes: minimum business requirements, minimum DM data requirements, physician-centric model and patient-centric model, competitive pricing, communication guidelines and best in class performance guarantees ▪ During Q3/Q4 2010, coordinate with health plans and HRA/LM carved-out programs to ensure implementation activities are effectively integrating all HM&DM programs and health plan programs 	<ul style="list-style-type: none"> ▪ Adapt HM&DM programs and contracts to ensure successful program results are achieved by monitoring operational and performance measures

CalPERS: Future Directions

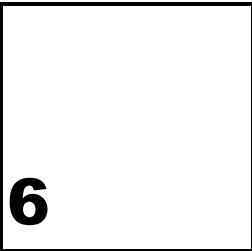
Core Elements	2009	2010	2011 & Beyond
Stakeholder engagement for optimal HM&DM programs	<ul style="list-style-type: none"> ▪ Work with constituent groups/public agencies to promote HRA participation ▪ Collaboratively work with health plans and provider groups to identify opportunities for improved HM&DM performance ▪ Engage constituent groups/public agencies to support CalPERS' programs in increased awareness, participation and to reinforce value across the membership 	<ul style="list-style-type: none"> ▪ Assess member participation rates in HRA/LM programs to determine the communications and incentives that are most effective in driving participation and engagement ▪ Continue to work with constituent groups/public agencies to promote HRA participation, in addition to engaging them to help increase awareness about CalPERS' HM&DM programs 	<ul style="list-style-type: none"> ▪ Review program participation rates and modify strategies as needed
Incentive strategy & design to encourage participation and healthy behaviors	<ul style="list-style-type: none"> ▪ Identify incentive options available through health plans ▪ Work with key constituent groups/state agencies to solicit input and gain support for a multi-year incentive strategy 	<ul style="list-style-type: none"> ▪ Finalize incentive strategy ▪ Launch, as appropriate, initial incentive to drive positive behavior and lifestyle changes 	<ul style="list-style-type: none"> ▪ Expand and adapt incentive offerings to drive desired behaviors in HM&DM as needed

CalPERS: Future Directions

Core Elements	2009	2010	2011 & Beyond
Comprehensive communication strategy to increase member awareness and value	<ul style="list-style-type: none"> Establish a CalPERS-specific brand for HM&DM programs Develop a multi-year communication strategy with key constituent group/state agencies that supports all communication methods (e.g., online, mail, etc.) Establish a strategy to tailor communications to fit CalPERS' diverse population in order to increase program awareness and participation 	<ul style="list-style-type: none"> Require health plans/carve-out vendors to consistently utilize CalPERS-specific brand for all member communications Establish quarterly vendor meetings to review HM&DM program performance in order to tailor communication efforts and increase program awareness and participation As necessary, implement communications aimed at increasing participation at certain constituent groups/state agencies based on data review 	<ul style="list-style-type: none"> Expand CalPERS-specific brand across care continuum as additional HM&DM programs are added (e.g., depression, DM) Continue vendor communication meetings to refine and leverage the most successful communications approaches and apply, as appropriate, to specific constituent groups/state agencies
Measurement & evaluation strategy	<ul style="list-style-type: none"> Add minimum operational and clinical performance monitoring metrics for HRA, LM and additional DM programs to monitor co-morbid conditions as defined within the report Expand contracts with health plans/carve-out vendors to include best practice performance metrics, minimum reporting requirements and performance guarantees 	<ul style="list-style-type: none"> Expand performance guarantees to include process improvement results (e.g., health risk change) Ensure contracts with carve-out DM vendor include minimum operational and clinical measures, and performance guarantees 	<ul style="list-style-type: none"> Enhance programs and services (e.g. delivery methods) based on analysis of operational and clinical program process and impact measures Implement ROI evaluation project based on 2010 measurement and evaluation strategy

CalPERS: Future Directions

Core Elements	2009	2010	2011 & Beyond
	<ul style="list-style-type: none">▪ Develop consistent data definitions and measurement methodologies for plans to use for data reporting▪ Assess CalPERS' capabilities to validate health plan/vendor reports and to plan tailored interventions for the population▪ Ensure contracts with carve-out HRA/LM vendor include minimum operational and clinical measures, and performance guarantees	<ul style="list-style-type: none">▪ Develop a measurement and evaluation approach to determine ROI of these programs using accepted methods (e.g. DMAA)	<ul style="list-style-type: none">▪ Conduct program operations and clinical audit to assess program performance▪ Conduct program outcomes study that is based on measurement and evaluation strategy developed in 2010



Single Administrator Implications

Although CalPERS has not decided if it will move towards a single administrator solution, Mercer does not recommend that the HM&DM and single administrator initiatives be directly linked for the following reasons:

- Best in class candidates will differ between the single administrator and HM&DM vendor lists
- Establishing a best in class HM&DM program is a long-term commitment and changing vendors is not recommended until after the new program has been in effect for three to five years.

Should CalPERS decide to carve out HM&DM programs, the following activities should be taken into consideration:

- **HM&DM Vendor Candidate Selection:** Some single administrators have HM&DM capabilities. Single administrator candidates should be qualified and considered along with carve-out vendors.
- **Request for Proposals (RFP):** The RFP and selection processes for both single administrator and carve out HM&DM programs should be mutually exclusive processes; however, business requirements around data exchange and member services/health advocacy support should be included in both procurement processes.
- **Contracting:** Contracts between a single administrator and the carve-out HM&DM program components should be mutually exclusive. Separate and distinct contracts allow for CalPERS to have more control over renewal processes or in future changes to vendors. Single administrator candidates should be willing to carve out HM&DM programs, which should be explicitly stated within any contract to avoid any misunderstanding.
- **Implementation/Integration:** Movement towards a single administrator will allow for simplicity of integration with only one medical plan and, in effect, simplifies efforts within the data warehouse to collect medical data.
- **Performance Monitoring:** The success of HM&DM programs will have some dependencies around data exchange; metrics should be monitored for both vendors, with process improvements implemented as opportunities are identified.

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